



Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name: _____ Date: _____
SS#: _____ Birthdate: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____ Cell Phone: _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
If Student, Name of School/College: _____ City: _____
 Full Time Part Time
Patient or Parent/Guardian's Employer: _____ Work Phone: _____
Business Address: _____ City: _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency: _____ Phone: _____

Responsible Party

Name of Person Responsible for this Account: _____ Relationship: _____
Address: _____ Home Phone: _____
Email: _____ Cell Phone: _____
Driver's License#: _____ Birthdate: _____
Employer: _____ Work Phone: _____ SS#: _____
Is this Person Currently a Patient in our Office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment in full at each appointment is expected.
 Cash Personal Check Credit Card I wish to discuss the office's payment policy

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#/SIN#: _____
Name of Employer: _____ Work Phone: _____
Employer Address: _____
Insurance Company: _____ Group #: _____
Insurance Address: _____
How Much is Your Deductible: _____ How Much have you Used: _____
Maximum Annual Benefit: _____ ID# : _____
Do You Have Any Additional Dental Insurance? Yes No (If yes, Complete the Following)
Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#/SIN#: _____
Name of Employer: _____ Work Phone: _____
Employer Address: _____
Insurance Company: _____ Group #: _____
Insurance Address: _____
How Much is Your Deductible: _____ How Much have you Used: _____
Maximum Annual Benefit: _____ ID# : _____

Patient Medical History

Physician _____ Office Phone: _____ Date Last Exam: _____

1. Are you under medical treatment now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	8. Are you allergic to or have you had any reaction to the following:	Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medications including non-prescription medical? If yes, what medication(s) are you taking _____	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use controlled substances	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have you had any of the following?			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	9. Women Only:		
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	8. Do you have frequent headaches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problem in your jaw?			14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to their party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. ***I understand that if my account is delinquent and is forced over to collections, I will be responsible for ALL collection and any attorney fees.***

(Signature of patient or parent/guardian if minor)

(Date)

Print Name

Employee Signature

Steven M. Hoffenberg, DDS, LTD Quyên Dang, DDS ~ Chu Lee DDS

264 Hawthorn Village Commons, Vernon Hills, IL 60061
(847) 367-6760

INSURANCE POLICY AGREEMENT

We are anxious to help you receive your maximum allowable benefits from your dental insurance.

As your dental care provider, we feel it is important that you understand that our relationship is with you, not your insurance carrier. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.

We are happy to help you process your primary and secondary insurance claims. We require you to contact our office when you receive your Explanation of Benefits from your primary carrier in order to help you process your secondary insurance claim.

We will try to answer any questions you may have relating to your insurance. Please realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. When your dental insurance carrier or coverage changes, we request you notify our office with your updated information.
2. Our fees are considered to fall within the acceptable range by most carriers, and, therefore, are covered up to the maximum allowance determined by each carrier and plan. This applies only to insurance carriers who pay a percentage of their usual and customary rate (UCR). U.C.R. is defined by the insurance companies as usual, customary, and reasonable fees. This statement does not apply to companies who reimburse based on an arbitrary *schedule* of fees, which often bear no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance carriers arbitrarily select certain services they will not cover. Our office is not responsible for monitoring each contract limitation.
4. Although your policy may state you have 100 percent coverage on either preventive or basic service, be aware that the yearly deductible may still apply.
5. Any information our office gives you regarding your insurance coverage is an *estimate*. We make these estimates based on information available to us. We are not responsible for any decisions regarding payment that the insurance company makes.
6. Almost all insurance policies have an annual maximum. This office is not responsible for monitoring the amount of benefits used to date. Please check with your insurance carrier to determine what benefits remain on your policy for the current year.

I have read, understand and agree to the above office policy. I understand that I am fully responsible for the fees of the services rendered, regardless of any insurance I may have.

Signature of Account Holder

Date

Steven M. Hoffenberg, DDS, LTD Quyên Dang, DDS ~ Chu Lee DDS

264 Hawthorn Village Commons, Vernon Hills, IL 60061
(847) 367-6760

WRITTEN FINANCIAL POLICY

Thank you for choosing the office of Steven M. Hoffenberg DDS LTD for all of your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Cash, Check, Visa, Master card, American Express or Discover Card

NO INTEREST Payment Plans from Care Credit or Chase Credit

- Allows you to pay over one year with NO INTEREST
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Steven M. Hoffenberg DDS LTD requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Patients are responsible for full payment regardless of Insurance

Steven M. Hoffenberg DDS LTD charges \$75.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I understand that if my account is delinquent and is forced over to collections, I will be responsible for ALL collection and any attorney fees.

Patient, Parent or Guardian Signature

Date

Employee

Date

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Steven M Hoffenberg, DDS • Quyen T. Dang, DDS • Chu N. Lee, DDS

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to *Dr. Hoffenberg or Associates*.

Dr. Hoffenberg and/or Associates Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective February 1, 2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you **.25** for each page and **\$15** per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Tara Fischer

Telephone: 847-367-6760

Fax: 847-367-6757

E-Mail: stevenhoffenbergdds@gmail.com

Address: 264 Hawthorn Village Commons

City, State, Zip: Vernon Hills IL 60061

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.

The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

_____ have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- D Individual refused to sign
- D Communications barriers prohibited obtaining the acknowledgement
- D An emergency situation prevented us from obtaining acknowledgement
- D Other (Please Specify)

#J312

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).